Guidance Document
Cost Center 766
MCH CORE ASSURANCE COORDINATION

As an adjunct to the Core Services Block Grant, MCH federal funding will be used as a grant to support staff doing MCH core service activities that are not reimbursable as patient care visits. The funding will supplement salary support for an MCH Core Assurance Coordinator (MCH CAC) at each local health department in order to fulfill the existing core functions listed in this document. The MCH CAC is responsible for the coordination of the required core MCH services to assure optimal population-based outcomes and is similar in nature to the role of a social worker in the health department. District health departments can determine if their allocation is split among the counties, worked from the district office, or a combination depending on the activities that need to be covered.

BACKGROUND: In Kentucky, the Title V Block grant has historically been utilized to provide funding to local health departments for services related directly to Maternal and Child Health. From an accounting standpoint, federal funds must be tracked separately and have less flexibility in their use; they require expenses to be incurred before money can be drawn down. This redesign is to allow these federal funds to provide an infrastructure to support the core services, particularly those that require assurance, by supplementing salary support for those staff carrying out the assurance functions.

SCOPE OF WORK: MCH COORDINATOR DUTIES AND RESPONSIBILITIES

a. The MCH CAC shall develop and maintain lines of communication and relationships with local care providers for women and children, local support agencies such as DCBS, and other local resources to facilitate the coordination of comprehensive care and support between the medical home, public health, and community agencies.
b. The MCH CAC shall assure that the core MCH functions listed in this document are carried out at their local health department. The MCH CAC does not have to directly perform each of these activities, but can provide assurance through oversight of these functions when appropriate.
c. The MCH CAC shall maintain open communication with the state MCH program and, upon request, assist the state department for public health in developing and assessing local MCH services, or in finding care and services for individuals from their area who have been identified with a need.
d. The MCH CAC shall provide input to the state MCH program and interpret and apply state program policy and guidelines to local MCH activities.

ELIGIBILITY: Local health departments who accept this federally-funded grant allocation must agree to identify one staff person to be the **MCH Core Assurance Coordinator (MCH CAC)** who dedicates time to these activities up to the limits of the funding. The name, employee ID, and contact information for the MCH CAC must be provided to the Title V program administrator prior to time being charged to this cost center.

Staff who can qualify to be the MCH CAC should be:

- Registered Nurse as allowed by the DPH Merit System, but NOT working in a CLINIC role, or
- Social Worker as allowed by the DPH Merit System, or
- Health Educator with a Master's Degree in a relevant field, or
- HANDS Supervisor if supervising less than 6 FSW's
- Registered Dietician with Master's Degree

✧ Health departments who wish to have more than one staff person or a staff person who does not fit in one of these categories to serve as the MCH CAC shall contact the state MCH program for approval. This funding will not support multiple staff, but one or two staff may be approved depending on the local need.

ALLOWABLE EXPENDITURES FROM THIS FEDERAL FUNDING: This cost center is only for charging staff time for the MCH CAC as listed below. If other staff are approved to code to this cost center (see above) then the staff person and the MCH CAC should not both code time for the same activity. First priority should be given to funding/budgeting to cover the MCH CAC's time, to the extent of the allocation. The MCH CAC, or other qualified people providing care coordination, must not be providing clinical services. No clerical staff can code time to this cost center.

NOT ALLOWABLE: No activity which is PEF'd or has a current funding stream is allowable to be coded to this cost center. The delivery of direct/individual personal health or preventative services cannot be charged to this cost center. Staff time for services normally done as part of a clinical visit is not to be coded to 766, as these services are part of the clinical visit. Community-based services, other than those specifically described here, should be coded to Cost Center 818. No clerical staff can code time to Cost Center 766. Additional examples of non-allowable services include: travel, supplies, materials, incentives, etc.

ALLOCATION METHODOLOGY: The allocations are determined according to a base of $10,000 per county, so that each county health department can have someone who can code time to these activities. Other factors in the allocation include the total number of low income children in the health department's jurisdiction from the previous fiscal year, and the total number of pregnant women who received PE or were served by the prenatal program in the health department the previous fiscal year.

SCOPE OF WORK: MCH COORDINATOR DUTIES AND RESPONSIBILITIES

PRENATAL/Maternity Care Coordination (Function Code 121)				
ACTIVITY	**RATIONALE**	**STAFF**	**ACTIVITY DESCRIPTION**	**ESSENTIAL PUBLIC HEALTH SERVICE**
1. Build network of Community providers	To facilitate the coordination of comprehensive care and support between the medical home, public health, and community agencies	MCH Coordinator	• Develop and maintain lines of communication and **relationships with local care providers** for women and children • Enhance collaborative relationships by participating with special projects or advisory boards with local community based organizations (i.e. Hospitals, DCBS, Comprehensive Care, community action or vision councils, etc.)	Mobilize Community Partnerships
2. Identify Community Resources	To assist women of childbearing age and children with information on community services for any need which for them is a barrier to health	MCH Coordinator	• Maintain and provide list of local community resources to patients identified in need of support (i.e. transportation, housing, employment opportunities, domestic violence, mental health services, children's advocacy services, financial counseling, etc.)	Inform, Educate, Empower

3. Communication with State MCH Program	Supports collaboration in developing and assessing local MCH services, and in finding care and services for individuals from their areas who have been identified	MCH Coordinator	• Assist with identifying local community resources • Attend MCH-required training events to learn best practices • Assist if requested with MCH local or regional MCH needs assessment • Share success stories with KDPH	Monitor Health; Diagnose and Investigate; Evaluate
4. Utilization Review of prenatal services	To evaluate the appropriateness, need and efficiency of LHD's prenatal services and compare to the minimum requirements of the prenatal program	MCH Coordinator	• Review LHD monthly Prenatal 439 e-Report (Services significantly above the minimum required should be reported to the LHD director or their designee to assist with plan and budgeting) • Participate with LHD QA/QI team program/chart reviews • Review monthly or as needed the *Prenatal 439 Report*	Monitor Health
5. Reporting Requirements	To systematically evaluate the effectiveness, accessibility and quality of services provided	MCH Coordinator and/or qualified designee	• Document MCH Coordination activities in Catalyst	Monitor Health; Evaluate
6. Presumptive Eligibility enrollment and tracking	To assure access to prenatal healthcare services	MCH Coordinator and/or qualified designee	• Assure **Presumptive Eligibility** enrollment and tracking for pregnant women presenting to the local health department ○ *All local health departments must assist pregnant women in enrolling for Presumptive eligibility per the current guidance in the AR.* • This includes: ○ Assisting patients in going to DCBS to enroll in Medicaid prior to the end of the presumptive eligibility, ○ Assuring enrollment for emergency Medicaid to cover the delivery, and ○ Assuring Medicaid enrollment for baby after birth, according to the specifics procedures in the AR.	Link to/ Provide
7. Link prenatal patients to pregnancy medical home	To assure/oversee the arrangements to link **any** pregnant women presenting to the LHD to have care with an obstetric	MCH Coordinator and/or qualified designee	• Remove any barriers to the pregnant woman attending the initial prenatal appointment, if necessary, including assisting or arranging for transportation • Confirm patient has attended initial prenatal appointment, if the	Link to/ Provide

	provider		prenatal provider is not in-house. (*Optional/Recommended)*	
8. Link pregnant women to support services	Provide/oversee the linking of **pregnant women** presenting to the health department **to all relevant support services**	MCH Coordinator and/or qualified designee	• Link pregnant women in need, who are not receiving clinical services at the LHD, to community resources and/or LHD support services such as WIC, Breastfeeding, HANDS, folic acid, and smoking cessation	Link to/ Provide
9. Accept calls and refer families to HANDS services	For those health departments who do not receive a HANDS allocation, Identify families potentially eligible for HANDS	MCH Coordinator and/or qualified designee	• For LHD's who do not receive a HANDS allocation and have HANDS services provided in their area by another provider, the MCH Coordinator in the LHD shall identify eligible families, and refer those families for HANDS assessment and services.	Link to/Provide
Pediatric Care Coordination (Function Code 122)				
ACTIVITY	**RATIONALE**	**STAFF**	**ACTIVITY DESCRIPTION**	**ESSENTIAL PUBLIC HEALTH SERVICE**
1. Build network of Community providers	To facilitate the coordination of comprehensive care and support between the medical home, public health, and community agencies	MCH Coordinator	• Develop and maintain lines of communication and **relationships with local care providers** for women and children • Enhance collaborative relationships by participating on advisory boards with local community based organizations (i.e. Hospitals, DCBS, Comprehensive Care, community action or vision councils, etc.)	Mobilize Community Partnerships
2. Identify Community Resources	To assist parents with information on community services for any need which for them is a barrier to health	MCH Coordinator	• Maintain and provide list of local and regional community resources (i.e. transportation, housing, employment opportunities, domestic violence, mental health services, substance abuse services, children's advocacy services, financial counseling, etc.)	Inform, Educate, Empower
3. Communication with State MCH Program	Supports collaboration in developing and assessing local MCH services, and in finding care and services for individuals from their areas who have been	MCH Coordinator	• Assist with identifying local community resources • Attend MCH-required training events to learn best practices • Assist if requested with MCH local or regional MCH needs assessment • Share success stories with KDPH	Monitor Health; Diagnose and Investigate; Evaluate

	identified			
4. Link pediatric patients to medical home	To provide/oversee the linking of **children** who present to a local health department **to a medical home with a primary care provider**	MCH Coordinator and/or qualified designee	• Arrange appointment with local pediatric provider link/establish the child with a medical home	Link to/ Provide
5. Reporting Requirements	To systematically evaluate the effectiveness, accessibility and quality of services provided	MCH Coordinator and/or qualified designee	• Document MCH Coordination activities in Catalyst • Review outcomes as supplied by MCH	Monitor Health; Evaluate
6. Repeat Newborn Screening Case Management *(See AR for further program details)*	To assure all newborns presenting to the health department have obtained **repeat Newborn Screening** *as the metabolic diseases may cause rapid deterioration that results in death within hours to days if not addressed*	MCH Coordinator and/or qualified designee	• Assist the state Newborn Screening program with finding children who are identified with positive tests that otherwise cannot be located • Assure that the child has a primary care provider who will see the child with suspicious or positive tests within 48hrs • In some cases, the LHD will perform the repeat metabolic screening tests	Link to/Provide
7. Identify community resources for Pediatric Obesity	To identify resources in the community for families needing to address pediatric obesity	MCH Coordinator and/or qualified designee	• Link patients not receiving clinical services at the LHD to community obesity prevention activities (i.e. LHD/Coordinated School Health, YMCA, County Extension Offices, local hospitals, etc.)	Inform, Educate, Empower
Child Fatality and Injury Prevention Care Coordination (Function Code 123)				
ACTIVITY	**RATIONALE**	**STAFF**	**ACTIVITY DESCRIPTION**	**ESSENTIAL PUBLIC HEALTH SERVICE**
1. Reporting Requirements	To systematically evaluate the effectiveness, accessibility and quality of services provided	MCH Coordinator and/or qualified designee	• Document MCH Coordination activities in Catalyst • Document CFR activities in Catalyst, including CFR team reporting form, due after each DFR team meeting Grief Counseling form after each	Monitor Health; Evaluate

			infant death	
2. CFR Coordination *(See AR for further program details)*	To provide/coordinate services coordinate with the **local CFR Team**	MCH Coordinator and/or qualified designee	• Assist the local coroner with the logistics of a team meeting when needed. • Represent Public Health at the local CFR team meetings and provide a report of the meeting to the State CFR coordinator in the format specified by the state program. • Maintain confidentiality forms for the local team and assure that each participating member has signed a form. Any violations of confidentiality should be reported to the State CFR coordinator. • Lead/coordinate the local implementation of recommendations from the child fatality review team.	Diagnose and Investigate; Mobilize Community Partnerships
3. Grief counseling information to families	To provide/ oversee the provision of information on **grief counseling** to local families who have had an infant death	MCH Coordinator and/or qualified designee	• Provide letter, including: condolences, suggest counseling, provide a list of local resources for counseling, and a number to call if the family wishes to request help finding counseling. • Link families requesting grief counseling services to a local grief counselor specially trained in infant/child deaths	Inform, Educate, Empower
4. Car seat installation checks	To assure local resources are available to families for **checking car seats** for proper installation	MCH Coordinator and/or qualified designee	• Refer families to local resources for car seat installation and/or check • LHD may, but is not required to, operate a car seat loaner program as described in AR. • Staff time to run the program should not be coded to 766.	Mobilize Community Partnerships
5. Coordinate local injury prevention community activities	To provide/coordinate services for the **local CFR team**	MCH Coordinator and/or qualified designee	• Lead/coordinate the planning of local implementation of recommendations from the child fatality review team. • Participate with local Safe Kids Coalition • The actual community activity should not be coded to 766.	Mobilize Community Partnerships

Childhood Lead Poisoning Prevention Care Coordination (Function Code 124)				
ACTIVITY	**RATIONALE**	**STAFF**	**ACTIVITY DESCRIPTION**	**ESSENTIAL PUBLIC HEALTH SERVICE**
1. Reporting Requirements	To systematically evaluate the effectiveness, accessibility and quality of services provided	MCH Coordinator and/or qualified designee	• Document MCH Coordination activities in Catalyst • Maintain and submit Lead Case Management tracking forms to the State Childhood Lead Poisoning Prevention Program	Monitor Health; Evaluate
2. Case Management of Children with Elevated lead levels *(See AR for further program details)*	To provide/oversee **Case Management for children identified as having elevated blood lead levels**	MCH Coordinator and/or qualified designee	• Track and provide case management to patients identified with elevated lead levels • Coordinate with the primary care provider, provide home visit, and family education for how to reduce exposures to lead *(The lead home visit can be billed as a clinical service through Pediatrics cost center 800)*	Enforce Legal Requirements to protect Health and Safety

OTHER ACTIVITIES: As with any federal grant, if the listed activities in this work plan can be accomplished and there is funding left over, the LHD can propose additional activities for this funding.

Staff time for implementing evidence-based practices in injury prevention (including co-sleeping and child abuse), and pediatric obesity prevention will be given top priority. This funding cannot be used for materials, incentives, or other parts of the implementation.

Proposals for these additional activities to be covered in this cost center should be submitted for approval to the Title V Administrator).